STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455429	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Rose Trail	930 S Baxter Tyler, TX 75701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than two hours after the allegations were made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury to the administrator of the facility and to other officials, including to the State Survey Agency, in accordance with State law through established procedures for four of eight (Resident #1, Resident #2, Resident #3, and Resident #4) residents reviewed for abuse and neglect. The facility failed to report an allegation of abuse which involved Resident #1 which occurred 04/19/2026 at 10:06 PM until 04/20/2026 at 3:43 PM. The facility failed to report an allegation of neglect which involved Resident #2 which occurred 05/16/2026 at approximately 1:00 PM until 05/17/2026 at 7:39 PM. The facility failed to report an allegation of abuse which involved Resident #3 and Resident #4 which occurred 05/23/2026 at 10:57 AM until 05/23/2026 at 4:06 PM. These failures could place residents at risk of not receiving timely investigation into allegations of abuse and neglect. The findings included: 1. A record review of Resident #1's face sheet dated 06/02/2026 indicated a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included chronic obstructive pulmonary disease with (acute) lower respiratory infection (a condition characterized by obstructed airflow due to inflammation and damage in the airways), cognitive communication deficit, unspecified lack of coordination, muscle weakness, and atherosclerotic heart disease of native coronary artery with unstable angina pectoris (a condition in which plaque buildup in the heart's arteries cause narrowing or blockage, leading to chest pain). A record review of Resident #1's most recent Quarterly MDS dated [DATE] indicated BIMS of 12, which indicated moderate cognitive impairment. Section GG of Resident #1's MDS indicated he was dependent on staff for toileting hygiene, showering/bathing, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. During an interview on 06/02/2026 at 9:23 AM, Resident #1 stated that LVN E verbally and physically abused him. Resident #1 stated while CNA A and LVN E were providing care he was picking on CNA A and LVN E told him, Don't talk to my [f word] aide like that. Resident #1 stated he told LVN E that she could not talk to him like that and LVN E continued cussing and stated you need these black women to take care of your white [a word] don't you. Resident #1 stated LVN E was rough while providing care and pushed him forward so hard he thought he would fall out of the bed. Resident #1 stated that LVN E closed his door after providing care despite him having asked her not to. Resident #1 stated the following morning he notified the DON that the event occurred. A record review on 06/02/2026 at 11:04 AM indicated that LVN E was suspended on 04/19/2026 due to alleged verbal and physical abuse. LVN E's personnel file indicated she was terminated on 04/21/2026. A telephone interview was attempted on 06/02/2026 @ 2:27 PM with CNA A, but she did not answer or return a voicemail. A record review on 06/02/2026 at 3:45 PM of the provider investigation report indicated a witness statement dated 04/19/2026 from CNA A (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455429	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Rose Trail	930 S Baxter Tyler, TX 75701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	which stated LVN E verbally and physically abused Resident #1. CNA A indicated in the witness statement that LVN E told Resident #1 to shut the [f word] up and [f word] you. CNA A indicated LVN E closed Resident #1's door and told CNA A you can open it, I'm not. CNA A indicated LVN E pulled Resident #1 hard during care. CNA A indicated the DON spoke with Resident #1 and afterwards she informed the DON of the incident. A record review of TULIP case details on 06/02/2026 at 3:49 PM indicated the report of abuse which involved Resident #1 was received by HHSC on 04/20/2026 at 3:43 PM. During an interview on 06/03/2026 at 9:04 AM, the DON stated he believed it to be the next day that he was notified of the alleged abuse by Resident #1. The DON stated he notified the ADM, suspended LVN E, and began investigating the allegation. The DON stated if a staff member witnessed abuse he expected them to follow policy and contact the ADM, the abuse coordinator, but typically staff notified him and he notified the ADM. A record review of Resident #2's face sheet dated 06/02/2026 indicated a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included parkinsonism (a brain condition that causes slowed movements, stiffness, and tremors), muscle weakness, active secondary progressive multiple sclerosis (progressive worsening of multiple sclerosis symptoms, including mobility and balance issues, weakness, fatigue, and sensory changes), and vascular dementia, severe, with agitation (changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain). A record review of Resident #2's most recent Annual MDS dated [DATE] indicated BIMS of 0, which indicated severe cognitive impairment. Section GG of Resident #2's MDS indicated Resident #2 was dependent on staff for toileting hygiene, required substantial/maximum assistance for eating, and required partial/moderate assistance for personal hygiene. Section GG of Resident #2's MDS indicated he utilized a manual wheelchair. An observation on 06/02/2026 at 9:48 AM revealed Resident #2 utilizing his wheelchair throughout the hall of the facility. Resident #2 did not stop when spoken to. A record review of a nursing note dated 05/16/2026 at 1:01 PM indicated Resident #2 was utilizing his wheelchair and fell backwards, hitting his head. The nursing note indicated Resident #2 was fighting staff who assisted him back into his wheelchair and was sent to the hospital. During an interview on 06/02/2026 at 1:28 PM, CNA B indicated she did not see Resident #2 fall but did hear a commotion and saw him lying down on the floor of the hallway. CNA B indicated she did not assist Resident #2 back into his wheelchair. CNA B indicated she returned to what she was doing at that time. A record review of the facility's provider investigation report on 06/02/2026 at 3:52 PM indicated an emergency department triage note dated 05/16/2026 at 1:55 PM which indicated Resident #2 complained of headache and back pain after the fall and had bleeding noted to his right great toe. Hospital notes dated 05/16/2026 at 4:16 PM indicated imaging which revealed a nondisplaced fracture of proximal phalanx of right great toe (a broken toe with the bones still in alignment). The provider investigation report indicated a witness statement dated 05/22/2026 by LVN F which indicated Resident #2 went down the hallway to his room, she heard a loud noise, and Resident #2 was found on the floor. The witness statement indicated that LVN F reported the incident to the physician who gave the order to send Resident #2 to the hospital, Resident #2's responsible party, and the DON. A record review of TULIP case details on 06/02/2026 at 3:55 PM indicated the report of neglect which involved Resident #2 was not reported to HHSC until 05/17/2026 at 4:43 PM. During an interview on 06/03/2026 at 8:32 AM, LVN F stated Resident #2 was had been going towards his room down the hall when she heard a loud bang and then found Resident #2 fallen backwards in his wheelchair. LVN F stated she assessed him, contacted the physician who instructed her to send Resident #2 to the hospital, and sent a group message to the ADM and the DON to notify them of Resident #2's unwitnessed fall and injury. LVN F stated unwitnessed falls with injuries were to be reported immediately to the ADM. During an interview on 06/03/2026 at 9:06 AM, the DON stated he was notified of Resident #2's fall and subsequent hospital visit. The DON stated once Resident #2 returned from the hospital and it was known that he had a fracture in his foot he notified the ADM. A record review of Resident #3's face sheet dated 06/02/2026 indicated a [AGE] (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455429	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Rose Trail	930 S Baxter Tyler, TX 75701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	year-old male who was admitted to the facility on [DATE]. Resident #3 had diagnoses which included transient cerebral ischemic attack (a temporary blockage of blood flow to the brain), muscle weakness, chronic obstructive pulmonary disease (a progressive lung disease that makes it difficult to breathe), and unspecified dementia. A record review of Resident #3's most recent Quarterly MDS dated [DATE] indicated BIMS of 11, which indicated moderate cognitive impairment. Section GG of Resident #3's MDS indicated Resident #3 was dependent on staff for toileting, shower/bathing, upper body dressing, lower body dressing, and putting on/taking off footwear. Section GG of the MDS indicated Resident #3 utilized a wheelchair. A record review of Resident #4's face sheet dated 06/02/2026 indicated a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #4 had diagnoses which included type 2 diabetes mellitus without complications (a chronic condition characterized by insulin resistance and high blood sugar levels), depression, heart failure, and muscle wasting and atrophy. A record review of Resident #4's admission MDS dated [DATE] indicated BIMS of 12, which indicated moderate cognitive impairment. Section GG of Resident #4's MDS indicated Resident #4 required supervision or touching assistance with toileting hygiene, shower/bathing self, upper body dressing, and lower body dressing. Section GG indicated Resident #4 utilized a manual wheelchair. During an interview and observation on 06/02/2026 at 9:18 AM, Resident #3 had some redness under and around his right eye. Resident #3 stated Resident #4 hit him with a closed fist a few weeks prior. Resident #3 stated he felt Resident #4 was trying to hurt him intentionally and he did not know why. Resident #3 stated he had no further interactions with Resident #4 and felt safe at the facility. During an interview on 06/02/2026 at 10:43 AM, Resident #4 stated he got into an argument with Resident #3 and hit him in the face with an open hand. Resident #4 stated he and Resident #3 were arguing prior to hitting him. Resident #4 stated Resident #3 was swinging his arms at him but did not land any hits. During an interview on 06/02/2026 at 1:41 PM, CNA C stated she identified the bruising on Resident #3's eye and asked him what happened. CNA C stated Resident #3 put his finger to his lips, made a punching motion, and pointed to his roommate Resident #4. CNA C stated she again asked Resident #3 what happened and he stated Resident #4 punched him. CNA C stated she immediately reported it to RN D and the DON. During an interview on 06/02/2026 at 1:43 PM, RN D stated CNA C had notified him of the bruising on Resident #3's eye and he assessed Resident #3 and Resident #4 and separated them. RN D stated he notified the DON and believed her notified the ADM but could not recall at what time. RN D stated he believed the reporting timeframe for abuse to be within 12 hours. A record review on 06/02/2026 at 3:20 PM indicated an alert note dated 05/23/2026 at 10:57 AM which indicated the aide alerted the charge nurse of new onset bruising around Resident #3's right eye. A nursing note dated 05/23/2026 at 11:55 AM indicated during routine rounds, CNA staff entered Resident #3's room and observed bruising to the right eye. The note indicated when Resident #3 was asked what happened he appeared fearful and pointed in the direction of his roommate. The note indicated Resident #3 stated his roommate had punched him several times in the face. A record review on 06/02/2026 at 3:30 PM indicated an alert note dated 05/23/2026 at 11:03 AM which indicated Resident #4 was the aggressor towards his roommate resulting in an injury. The note indicated Resident #4 was moved to a new room. The note indicated the physician, DON, and ADM were notified of the event. A record review of TULIP case details on 06/02/2026 at 3:58 PM indicated the allegation of abuse regarding Resident #3 and Resident #4 was not reported to HHSC until 05/23/2026 at 4:06 PM. During an interview on 06/03/2026 at 9:10 AM the DON stated he was notified of the alleged abuse regarding Resident #3 and Resident #4 on 05/23/2026 at 10:33 AM by text message from CNA C. The DON stated he reported this immediately to the ADM. The DON stated he believed the timeframe for reporting abuse and neglect to HHSC to be within 24 hours and when he learned of any allegations he notified the ADM immediately. During an interview on 06/03/2026 at 9:53 AM, the ADM stated she was not aware the allegations of abuse and neglect were not reported within the 2-hour timeframe. The ADM stated in-services on abuse, neglect, and exploitation are held regularly and staff are educated to notify her, the abuse coordinator, if there are suspicions of abuse (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455429	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Rose Trail	930 S Baxter Tyler, TX 75701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	or neglect. The ADM stated that staff, particularly staff identified in the allegations regarding Resident #1, Resident #2, Resident #3, and Resident #4 have been educated to report abuse and neglect to her. The ADM stated the form for self-reported incidents can require lengthy information and that may have contributed to untimely reporting along with gaps in communication with staff. Record review of the facility's policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program revised April 2021 indicated the following: The resident abuse, neglect, and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: 9. Investigate and report any allegations within timeframes required by federal requirements. Record review of the facility's policy titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating revised September 2022 indicated the following: Policy StatementAll reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Policy Interpretation and ImplementationReporting Allegations to the Administrator and Authorities If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law and HHSC reporting guidelines. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies:The state licensing/certification agency responsible for surveying/licensing the facility. Immediately is defined as:Within two hours of an allegation involving abuse or result in serious bodily injury; or Within 24 hours of an allegation that does not involve abuse or result in serious bodily injury